Mid-State Health Network

April 2017 Newsletter

From the CEO's Desk

Joseph Sedlock

Chief Executive Officer

The Michigan Department of Health and Human Services submitted the final report of the Section 298 Facilitation Workgroup to the Michigan Legislature on March 15, 2017. As a member of the Workgroup, I can comfortably say that it reflects broad consumer, other stakeholder, and citizen input and strong consensus of the workgroup's members. In almost every way, the recommendations have strong potential to improve services, physical-behavioral health integration and public accountability for performance.

Recall that the original February 2016 budget bill called for taking $2.6 billion from the public mental health system and turning those resources over to private insurance companies/Medicaid Health Plans. This action shocked and disgusted most that receive services, care for, support and advocate for individuals served, their family members and friends with disabilities. The original proposal contained in section 298 proposed to toss away over 50 years of experience and expertise of one of the nation's most progressive behavioral health systems, Michigan's, and would turn it over to the private/for-profit insurance industry.

The reaction then was as swift and as visceral as it is now -- "Hell no!"

There comes a time to take a stand. We have reached that point when it comes to structuring a service delivery system for some of the most vulnerable citizens of our state (persons with serious mental illness, children with emotional disturbances, persons with intellectual and developmental disabilities and substance use disorders).

Persons served, parents/family members, advocates, providers and some members of the public fear - with good reason - that the valued Michigan public mental health safety net will be ripped to shreds. The language and its interpretations sent shivers down our spines. Given the struggles to achieve what we have, our worries are not ill-founded.

The 298 stakeholder processes of the last year brought together a massive cross-section of citizens, consumers, advocates, family members, providers, and payers, including private insurance companies, to study the issue of how to best operate,

structure and finance our system of care to improve and integrate physical and behavioral health services and reduce administrative levels and costs.

The Final Report of the 298 Facilitation Workgroup as submitted to the Michigan Legislature can be found at www.michigan.gov/stakeholder298.

The 298 Workgroup's report is crystal clear on over 70 thoughtful recommendations put forth as a sensible way forward. *One unequivocal position is that we maintain public oversight and management of public behavioral health dollars, and not relinquish our moral charge to assist in supporting the dreams and aspirations of the most vulnerable persons to the private/profit health plans/insurance companies*.

We now hear strong rumblings that the Snyder Administration and Legislative leaders are going to toss out a year's worth of citizen engagement and the very foundation that the 298 Workgroup built its recommendations on (keeping the oversight and control of the public resources dedicated to specialty behavioral healthcare in public control) and allow the Health Plans to have some or all of these public resources to manage--in direct conflict with the citizens' recommendations.

These rumblings, if true, seem to be driven, not by sensible public policy--but by ideology, money and politics. (Remember that the goals were stated to have been better physical-behavioral health integration). This happens where people get care - in communities. System design decisions that are now at hand should be based first on the will of the people, the public good, the interests of the men, women and children with severe disabilities who are citizens of our state and served by our system, and solid information about system performance and cost.

We have respectfully asked the Governor, Legislature and the Department of Health and Human Services not to place politics above care and service and to retain public management and accountability of the specialty behavioral healthcare system. We continue to look to government leadership of our State to uphold the covenants and tenants of the citizens of Michigan through the 298 Facilitation Workgroup that was legislatively empowered to study these important issues and make recommendations to them.

The lives of hundreds of thousands of persons is in the Michigan's Legislature's hands.

Mid-State Health Network will work vigorously to support the implementation of the recommendations of the 298 Facilitation Workgroup. We ask you to join us in this work to defeat the threat posed by turning the systems resources over to Michigan's Medicaid Health Plans while at the same time working to strengthen our system through the implementation of the more than 70 policy recommendations. Our system must continue to be publicly accountable, publicly managed and consumer-driven.

Please contact Joe Sedlock with questions or concerns related to the above information and/or MSHN Administration at Joseph.Sedlock@midstatehealthnetwork.org.

Organizational Updates

Amanda Horgan

Deputy Director

MSHN's Staffing Changes

MSHN is pleased to announce that we have hired the following three new employees,

who joined us on April 10, 2017.

- **Amy Dillon**, Quality Assurance & Performance Improvement Manager, who previously worked at the Michigan Department of Health & Human Services as the Weatherization Assistance Program Specialist. This is one of two positions that were approved in the MSHN budget in September 2016.
- **Barb Groom**, Waiver Coordinator, who previously worked for Clinton, Eaton, Ingham Community Mental Health Authority as the Autism Coordinator. This position is needed to incorporate the additional PIHP responsibilities for the Home and Community Based Services Transition and will permit the existing staff to focus exclusively on these greatly expanded responsibilities under Federal rule and the MDHHS/PIHP Contract.
- **Jennifer McCoy**, Office Assistant/Receptionist, who comes to us with experience in administration, management and non-profits. Jennifer replaces Leathia Hodge, who left MSHN a couple of months ago.

In addition, the following staff have transferred to other roles within MSHN:

- Jeanne Diver accepted the Treatment Specialist position, effective April 1, 2017. Jeanne has been our customer services specialist and is transitioning to the new position that was vacated by Melissa Davis.
- Melissa Davis accepted the Quality Assurance & Performance Improvement Manager position. This position is the second of two positions that were approved in the MSHN budget in September 2016. The effective date of this internal transfer is being determined.

Please join us in welcoming the newest members to the MSHN team and our current staff to their new roles!

National Committee for Quality Assurance (NCQA) Readiness Assessment

As authorized by the MSHN Board, Mid-State Health Network, along with Lakeshore Regional Entity and Region 10 PIHP, entered a joint consulting arrangement with The Mihalik Group to assist our organizations with understanding NCQA standards under the Managed Behavioral Healthcare Organization (MBHO) accreditation and to assess our organizational readiness. The Mihalik Group conducted an on-site visit during March with Leadership members and staff that included reviews on the following elements:

- Delegation
- Provider Network Contracts and Availability of Providers
- Accessibility of Services
- Member Experience
- Complex Case Management & Care Coordination
- Utilization Management
- Credentialing
- Members Rights & Responsibilities, and
- Behavioral Health Screening & Self-Management

MSHN Leadership has recently obtained the results of the assessment and will begin

the action planning process for areas identified for improvement. In addition, MSHN will be working with our PIHP partners to review opportunities to conduct joint planning efforts, potentially including sharing staff and other resources. More information will be forthcoming as we work towards efforts to assure compliance with high quality assurance standards.

Please contact Amanda Horgan with questions or concerns related to MSHN Organization and/or the above information at Amanda.Horgan@midstatehealthnetwork.org.

Information Technology

Forest Goodrich

Chief Information Officer

MSHN has moved into the planning and development phase of the Managed Care Information Systems project (MCIS). We have a negotiated contract and will begin several working meetings where PCE Systems staff meet with MSHN staff and work through the details of functional areas and how they should work in the computer application.

The project team will evaluate key areas, such as:

- Substance Use Service Reporting to MDHHS
- Utilization Management Activities
- Quality Improvement Processes
- Financial Management and Claims Processing
- Provider Network Credentialing and Contract Management
- Prevention and Treatment Efforts
- Health Information Exchange
- Population Health Tracking
- Customer Services
- Grievance and Appeals

As we go through this process, the outcome is clear specifications for PCE Systems to use when doing the design phase of the project. In order for the MSHN team to have a successful implementation and to achieve its objectives, PCE Systems will need to customize some of the features to match our processes, including the substance use disorders module.

Data conversion, migration and historical reporting will be clearly defined during the summer months, so that by fiscal year 2017-2018, we can begin to use the tools and reporting in the MCIS.

This project is slated for six to nine months from planning to implementation, so please expect more updates in the coming months.

Please contact Forest Goodrich with questions or concerns related to MSHN Information Technology at Forest.Goodrich@midstatehealthnetwork.org or 517.253.7549.

Finance News

Leslie Thomas

Chief Financial Officer

Departmental Updates

The Finance Department has submitted year-end reporting to the Michigan Department of Health and Human Services (MDHHS). The bundle includes Financial Status, Utilization Net Cost (UNC) by fund source, Administrative Costs and Hospital Reimbursement reports. MSHN auditors have also conducted on-site field work for its Fiscal Year 2016 Financial and Single Audits. MSHN auditors will be conducting our Compliance Examination in May 2017. We have finalized numerous reports and presented to MSHN's Operations and Finance Councils. The intent of the new reports is to provide more useful information for decision-making purposes. It also enhances accountability for the information being reported to and by MSHN on an interim basis.

The Finance Department is conducting a revenue analysis to determine the impact of fiscal year 2017 quarters' three and four rate changes. We do not anticipate a significant impact to the region.

MSHN continues to work with certain Substance Abuse Prevention and Treatment (SAPT) providers in assessing their fiscal payment arrangements. Numerous efforts have been made to resolve provider concerns as it relates to contract changes and to also provide technical assistance needed in order to reach certain utilization and spending targets.

Please contact Leslie Thomas with questions related to MSHN Finance at Leslie.Thomas@midstatehealthnetwork.org.

Utilization Management

Dr. Todd Lewicki, PhD, LMSW

Utilization Management & Waiver Director

Phase One and Phase Two Home and Community-Based Service Rule Transition Beginning

In mid to late-April, Mid-State Health Network (MSHN) expects to begin the process of determining provider compliance with the Home and Community Based Services (HCBS) Rule changes. HCBS services provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings. Phases One and Two of the process are comprised of persons on the Habilitation Supports Waiver (HSW). Remediation activities for these two phases will be addressed in one process, whereby MSHN will determine which residential and non-residential providers require plans of correction to bring them into compliance with the HCBS Rule changes. This will involve letters to providers indicating what needs to be addressed. In-region providers will in turn share their corrective plans with MSHN, who will review the plans and provide feedback and/or approval.

MSHN is working with each of its Community Mental Health Service Programs (CMHSPs)

to coordinate and ensure community planning and collaboration around addressing areas of HCBS corrective action needs. Phases One and Two total count of persons was approximately 1,600 persons. After these two phases, the "B3s," or services available to eligible persons under the authority of 1915(b)(3) of the Social Security Act, will also be surveyed. Persons in the B3 count total 4,300. Thus, MSHN will be very involved in working with CMHSPs and providers to ensure that any necessary corrections are made to address changes and consistency in implementation of the HCBS Rule requirements.

Please contact Dr. Todd Lewicki with questions or concerns related to MSHN Utilization Management and/or the above information at Todd.Lewicki@midstatehealthnetwork.org.

Treatment & Prevention

Dr. Dani Meier, PhD, LMSW

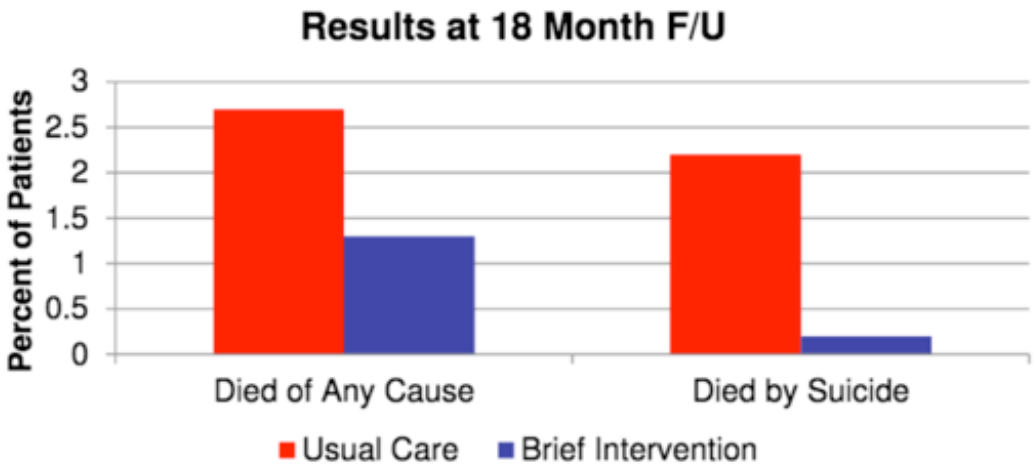
Chief Clinical Officer

The Importance of Aftercare Following Hospitalization

Recent research has highlighted the importance of coordination of care and, in particular, of *aftercare* following inpatient psychiatric hospitalizations. The period after discharge from an inpatient stay is the time of highest risk for death by suicide by those receiving mental health care. A 2009 study of 900,000 veterans treated for depression, for example, revealed that the highest risk for suicide was in the 12 weeks following discharge.

This data and other studies suggest that health systems could have a significant impact on reducing suicides if they allocate resources for prevention efforts for depressed patients recently discharged from inpatient psychiatric settings.

A randomized study of 1,867 suicide attempt survivors offered a one-hour intervention as soon after the attempt as possible, as well as 9 follow-up contacts (phone calls or visits) over the next 18 months. The experimental group that received the post-discharge interventions had an over 75% reduced rate of death by suicide from the control group who received usual care. Not surprisingly, given what we know about the mind-body connection, the interventions also reduced the rate of any-cause deaths by roughly 20%.



In another study, a nationwide effort in Taiwan to intervene in Emergency Departments with over 50,000 suicide attempt survivors showed a 63.5% reduction in suicide attempts by those who accepted the intervention program.

The implications of this research for MSHN's "Better Care" strategic goal and for MSHN's provider network is clear. Upon discharge from inpatient psychiatric hospitalizations where (ideally) consumers have been "stabilized," we need to diligently implement evidence-based aftercare processes, throwing a wide safety net during that critical period when we know that at-risk consumers are by no means "out of the woods." MSHN's Clinical Team is making this a top priority in our work with our CMH partners as well as with our SUD provider network, where effective follow-up after detox and residential episodes of care can prevent relapses, overdoses and can help save lives.

MSHN/Medicaid Health Plan Collaboration: 30-Day Follow-up After Hospitalization for Mental Illness (HEDIS) Measure

Related to follow-up after hospitalization is the HEDIS measure, which requires follow-up within 30 days . Linked HERE is MSHN's preliminary report, dated November, 2016, showing the region's performance as well above baseline. As a reminder, we need to differentiate this between the Michigan Mission-Based Performance Indicator System (MMBPIS) measure, which permits us to exclude certain people for certain reasons (refused follow-up appointment, for example) from the numerator, which puts our 7-day follow-up above 95% for both adults and children. An extract of pertinent information is linked HERE as well.

Please contact Dr. Dani Meier with questions or concerns related to MSHN Clinical Operations and/or the above information at Dani.Meier@midstatehealthnetwork.org.

Provider Network Updates

Carolyn T. Watters, MA
Director of Provider Network Management Services

Improving Access to Care with a Bed Availability Registry

As noted in the February Newsletter, MSHN has been working with Health Management Associates (HMA) to conduct research into the success and challenges of psychiatric inpatient registries. The draft report is expected to be finalized within the next couple of weeks. Our next step is to coordinate a key stakeholder meeting where HMA will share the report and facilitate dialogue to obtain stakeholder feedback.

Regional Psychiatric Inpatient Operations Workgroup Update

The MSHN Operations Council created an ad hoc, temporary, Regional Psychiatric Inpatient Operations Workgroup to make recommendations to MSHN and participating CMHSPs with regard to standardizing, across the MSHN region, clinical procedures, forms, tools and systems as well as administrative procedures, forms, tools and systems that are associated with psychiatric inpatient care, provider network procurement (including contracting), provider network management (including provider performance monitoring and performance improvement), credentialing and privileging, and any other related systems. The workgroup is comprised of Emergency Services staff, Clinical staff, Provider Network Management staff, and Finance staff.

Linked HERE is the Workgroup's Action Plan. The responsibilities and duties of the Regional Psychiatric Inpatient Operations Workgroup include the following, with all work expected to be completed by June 2017:

- Develop a single set of psychiatric inpatient provider performance standards, including pre-admission, admission, continuing care, discharge, and aftercare as well as contract compliance, performance improvement, and any related/applicable administrative standards;
- Develop a single, regional psychiatric inpatient provider performance monitoring (site review) template;
- Develop standardized tools for routine operations in the areas of initial authorizations, continuing stay reviews, discharge plans, and related clinical processes, procedures and forms;
- Develop a single psychiatric inpatient provider contract template;
- Develop any necessary recommended policies, procedures, forms, templates or other tools necessary to achieve regional consistency and standardization of operations.

For questions or concerns related to MSHN Provider Network Management, and/or the above information, please contact Carolyn at Carolyn.Watters@midstatehealthnetwork.org.

Quality, Compliance & Customer Service

Kim Zimmerman

Director of Quality, Compliance and Customer Service

HIPPAA Privacy Rule

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule establishes national standards to protect individuals' medical records and other personal health information. The rule applies to covered entities such as health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically.

Compliance with the Privacy Rule was required as of April 14, 2003 for most entities covered by HIPAA, and by September 23, 2013, it became effective for their business associates.

As of February 2017, the Office of Civil Rights (OCR) has received over 150,507 HIPAA complaints nationwide since April 2003.

In order to resolve these cases, the OCR has required changes in privacy practices, corrective actions and providing technical assistance to HIPAA covered entities and their business associates. Some corrective action in areas of non-compliance result in civil monetary penalties and to date, the OCR has settled 47 cases that have resulted in a total dollar amount of $67,210,982.00.

The compliance issues that are investigated the most include the following in order of frequency:

- Impermissible uses and disclosures of protected health information;
- Lack of safeguards of protected health information;
- Lack of patient access to their protected health information;
- Use or disclosure of more than the minimum necessary protected health information; and
- Lack of administrative safeguards of electronic protected health information

The most common types of covered entities that have been required to take corrective action to achieve voluntary compliance are, in order of frequency:

- Private Practices;
- General Hospitals;
- Outpatient Facilities;
- Pharmacies; and
- Health Plans (group health plans and health insurance issuers)

One of the most effective ways to ensure compliance with the HIPAA Privacy standards is by having an effective compliance program. The Office of Inspector General defines the following seven elements as being a part of an effective compliance program:

1. Implementing written policies and procedures
2. Designating a compliance officer and compliance committee
3. Conducting effective training and education
4. Developing effective lines of communication
5. Conducting internal monitoring and auditing
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected problems and undertaking corrective action

The Mid-State Health Network (MSHN) Compliance Plan includes these seven identified elements.

In 2016, MSHN did not have any compliance complaints that included HIPAA Privacy Rule related offenses.

For questions or concerns related to MSHN Quality, Compliance and Customer Service, please contact

Kim Zimmerman at Kim.Zimmerman@midstatehealthnetwork.org.

Mid-State Health Network (MSHN) exists to ensure access to high-quality, locally-delivered, effective and accountable public behavioral health and substance use disorder services provided by its participating members.

STAY CONNECTED